

# TECHNOLOGY AND TREATMENT: TELEMEDICINE IN THE VA HEALTHCARE SYSTEM

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## FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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## **TECHNOLOGY AND TREATMENT: TELEMEDICINE IN THE VA HEALTHCARE SYSTEM**

**Tuesday, August 9, 2016**

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON VETERANS' AFFAIRS,  
SUBCOMMITTEE ON HEALTH,  
*Washington, D.C.*

The Subcommittee met, pursuant to notice, at 9:00 a.m., at the Camarillo Public Library, 4101 East Las Posas Road, Camarillo, California, Hon. Brad Wenstrup presiding.

Present: Representatives Wenstrup and Brownley.

### **OPENING STATEMENT OF BRAD WENSTRUP, ACTING CHAIRMAN**

Mr. WENSTRUP. Good morning. And I want to thank you all for joining us today.

The Subcommittee will come to order. My name is Brad Wenstrup. I am a veteran, a doctor, and a Congressman from the 2nd District of Ohio, and Member of the U.S. House Committee on Veterans Affairs.

I am here today as Acting Chair of the Committee on Health. And I am so grateful to be with you here today in Southern California.

Actually, my notes said "sunny California," but that is not what we have here today. But that is okay.

I am accompanied by your Congresswoman and the Ranking Member on the Subcommittee on Health, Julia Brownley, and my friend and colleague.

As many of you know, Ms. Brownley is a reliable advocate for veterans and their families, and her focus on the Committee has always been finding ways to improve the lives of veterans at home, here in California, and across the country.

I am grateful to her for her hard work, and for inviting me to be here with her this morning.

Before continuing, I would ask all of the veterans in our audience today to please stand, if you are able, or raise your hand and be recognized.

Thank you all so very much for serving, and it is an honor to have you here today.

We are here today to continue our mission of improving the Department of Veterans Affairs' health care system, and to ensure that you and all those that have fought, served, and sacrificed for our country receive the care that you have earned and deserve.

As a veteran and doctor, I understand firsthand the importance of providing timely and high quality care to our Nation's heroes. And as a Congressman and a Member of this Committee, I have seen time and time again where the VA has sometimes come short to provide such care to veteran patients.

There is a lot of positives. We have a lot of great providers, people out there wanting to take care of our veterans. Sometimes it is the system that fails us.

So getting VA health care on the right track requires us to use every available tool at our disposal to increase access to care.

Now, one of those tools is telemedicine. Telemedicine is the process of using telecommunications technology to remotely diagnose and treat patients. And it has obvious advantages for veterans, particularly for those in rural or medically underserved areas, or for those who have difficulty traveling to a VA medical facility.

For example, using telemedicine could allow a veteran at the Oxnard Community Based Outpatient Clinic, CBOC, to see a specialist at the West L.A. VA Medical Center without having to fight traffic there and back.

VA purports to be a leader in the use of telemedicine. And, according to testimony VA will provide this morning, there were more than 2 million telemedicine visits across the VA health care system last fiscal year alone.

The Commission on Care recognized that the VA is excelling at telemedicine and recommends that they expand the use of it.

As the use of telemedicine continues to expand, we need to be sure that VA is keeping pace with modern technology, and is effectively safeguarding private medical information through secure data channels.

We also need to explore whether the VA is effectively tracking telemedicine appointments to ensure consistent, quality care and monitoring patient outcomes.

If VA truly is a leader in deploying telemedicine, it is important to track best practices, lessons learned, and the impact telemedicine is having both on individual patients, and on the VA health care system as a whole, as well as to ensure that this technology is being leveraged to address the critical issues VA is facing today.

For example, VA touts telemedicine as an important way to increase access to care.

That may be true, but one can't help but notice that while the use of telemedicine has been increasing over the last several years, patient wait times have been increasing in some areas as well.

Why is that? More importantly, how can we better utilize telemedicine technology to improve the care and the experiences that our veterans receive?

I look forward to discussing these questions this morning.

I now recognize Ranking Member Brownley for her opening statement.

#### **OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER**

Ms. BROWNLEY. Thank you, Mr. Chairman. And really thank you for joining us today and traveling here to Ventura County for, I believe, an important hearing that is going to take place.

I appreciate you coming all the way from your hometown, Cincinnati, Ohio. And I do welcome you to sunny Camarillo because the sun will indeed come out. And we are really, really happy to have you here.

I want everyone in the audience to know that Dr. Wenstrup is an extraordinary Member of Congress. We were elected together. He is an M.D., as he mentioned, but also has served in service as a medical doctor. He is an Iraq veteran.

And I think, like your district, my district is a district that is very rich because of its military families and veterans.

So I think we both represent very very unique districts because I think the fabric of our community is, as I said, very very rich due to all the military families and veterans who live here.

I want to thank our witnesses for joining us today to discuss this important issue.

As technology continues to improve, the possibilities for providing health care are also rapidly changing.

Companies and providers, many of them from California, I might add, are pushing the envelope on how we approach health care.

One example of this is the growth of telemedicine, telehealth. So what does that really mean? Dr. Wenstrup just defined what telehealth is. The Health Resources and Services Administration defines it as the use of electronic information and telecommunications technologies to support long-distance clinical health, patient and professional health-related education, public health, and health administration.

These are innovative technologies and systems that can make health care more accessible across geographic locations. It can break down barriers between health care experts, and patients who may be in different cities, different States, or even the other side of the globe. Today's hearing will focus on the use of telehealth within the VA health care system.

As we know, there is not a one-size-fits-all approach to providing health care to veterans. The VA health care system serves nearly 9 million people, men and women, with different needs and preferences about their health care.

Telehealth services are available for the VA to make diagnoses, manage care, perform checkups for veterans who may have trouble accessing their local regional medical center, or for those who need an appointment with a specialty provider not available locally.

In 2015, the VA provided, by far, the most Federal telehealth appointments, with 2.1 million consultations to over 677,000 veterans. And the VA expects the number of telehealth appointments to increase by over 12 percent in the coming year.

I am looking forward to learning more about what the VA is doing to give the program greater visibility, and what benefits they anticipate from the use of these technologies.

I am also interested in knowing how the VA is getting the word out about the availability of telehealth at the remote clinics, how veterans are being notified that telehealth is an option, and what strategies and technologies from the private sector the VA can look at to promote telehealth.

Expanding telehealth appointments is especially important when we consider the ongoing provider shortage at the VA and across the health care sector in general.

Secretary McDonald has testified about the VA provider shortage and the need to recruit doctors and other medical professionals to address this shortage.

We also know that there is a provider shortage not just at the VA, but really throughout the Nation.

We should look at ways that telehealth can help mitigate this challenge, and connect doctors and specialists with the patients who need them, regardless of geographic location.

Again, I am looking forward to learning more about the VA's approach to telehealth, and how this approach fits together with the ultimate mission of providing quality and timely care for our veterans.

Here in Ventura County, we struggle with a community clinic that is still too small to serve the needs of all of our veterans. Although we are working diligently to address this problem, the VA Choice program does not adequately take into account driving time for veterans to access care.

And as we all know, traveling the 101 to Sepulveda or West Los Angeles for an appointment can take the better part, or all of one's day.

So it is particularly important to me that Ventura County veterans have access to advanced technology, like telehealth, that will increase the quality and timeliness of their care that they have earned and deserved.

Thank you, Mr. Chairman. And I yield back the balance of my time.

Mr. WENSTRUP. Thank you very much.

We are going to begin today's hearing with our panel of witnesses, who are already seated at the table.

And I am going to yield momentarily to Congresswoman Brownley to introduce our witnesses.

But first, I would like to thank them all for their presence and participation here this morning. And for their service and for the work that they do for our veterans.

I would also like to gently remind all of today's witnesses to please be mindful of the 5-minute time limit for your oral testimony and the question-and-answer period that will follow.

The light has been placed in front of me and in front of you, and will change from green to yellow when there is one minute left, from yellow to red when the time has expired.

So we are going to try to stay as close as we can to the 5-minute time limit as possible so we can be sure that everyone has a chance to be heard. And I want to thank you in advance for that consideration.

Now, Ranking Member Brownley, would you please introduce our panelists.

Ms. BROWNLEY. I will indeed. Thank you, Mr. Chairman.

And, again, thank you for coming to this great county for our hearing today. And I appreciate your travels coming here, and looking forward to a great hearing.



And I would like to welcome all of you here today. And I am looking forward to this important topic. We have a great panel of witnesses here with us who have graciously taken the time to share their perspectives on this topic.

I would like to take a moment to briefly introduce our witnesses.

Joining us today from the VA are Dr. Kevin Galpin, the Chief Consultant of VHA Telehealth Services. He is responsible for overseeing the implementation and coordination of telehealth technologies throughout the VA.

With him is Dr. Hartronft, Chief of Staff of the VA Greater Los Angeles Healthcare System.

And also joining us today is Dr. Herb Rogove, the President and Chief Executive Officer of C30 Telemedicine, based here in Ventura County.

And last, but not least, also here is Dr. Zachary Walker.

Mr. WALKER. No "doctor."

Ms. BROWNLEY. Mr. Zachary Walker. A U.S. Navy veteran, most important title, and Ventura County Probation Agency employee, who will share his personal experience using telemedicine at our local VA. So thank you all for being here.

And for audience members who are interested in sharing their comments or perspectives on telemedicine at the VA, my staff will be available after the hearing. They will be happy to take down your contact information and let you know where you can submit written comments that we will then share with the Veteran Affairs Committee back in Washington.

So thank you very much. And I yield back.

Mr. Wenstrup. Thank you.

We will begin with Mr. Walker. Sir, you are recognized for 5 minutes.

#### **STATEMENT OF ZACHARY D. WALKER**

Mr. WALKER. Good morning, and thank you for the opportunity to give my testimony with my experience with telemedicine.

I am Zachary Walker, a veteran of the United States Navy, 1975 to 1979.

My introduction to telemedicine was presented to me by my VA medical clinic not as an option, but as a last resort.

My journey began when I received a phone call from my local VA clinic one day before my scheduled appointment, that my appointment had been canceled. The clinic informed me that my health care provider was not available. I was told the next available appointment would be within 2 months.

Having already waited 2 months for an appointment, I requested to see the next available health care provider.

Again, I was informed that the wait time would be 2 months because they were all booked.

I took the next available appointment, now having to wait 4 months to see a provider.

I terminated the call feeling frustrated and angry that my health care was being jeopardized due to the backlog in the system.

The next week, I called my VA clinic and asked to speak to a supervisor, who was not available. I then provided my information for a return call.

Not having received a returned call for 2 days, I again called the clinic and spoke with a supervisor. I reiterated my story, but it was apparent that she was unable and unwilling to help.

She gave me some unclear information about how to proceed if my condition worsened, which I felt was not a solution to my problem.

Out of desperation, I called my local VA representative and explained my situation.

To my surprise, I received a call the next day from a clinic nurse who presented the option of telemedicine.

Initially, I was reluctant because being seen by a doctor through a monitor was counterproductive to any medical experience I had in the past.

The nurse was thorough, explaining the process, and assuring me that the doctor would have my lab results. And she would also review my medical history. I scheduled an appointment and was seen within a week.

I arrived for my appointment and was escorted back to an examination room in a timely manner. I was seated in front of a monitor and a two-way camera. The doctor introduced herself. She was very pleasant, did not appear rushed, and she was well prepared. It was evident, based on her questions, that she had reviewed my recent tests and medical history.

During my appointment, the doctor ordered more tests and made a referral for a new medical condition that she noted. She even apologized for not having the ability to examine me.

Even more surprisingly, I received a call from her one week later with my test results.

In conclusion, I had a great experience with telemedicine. My appointment wait time was reduced from 2 months to 1 week. My appointment started on time rather than a normal 1-hour lobby wait time. The doctor was not rushed during my appointment, and took the time to listen to my concerns.

The only obvious drawback is not having a doctor to physically examine you. But I would use telemedicine in the future.

Telemedicine should be presented to veterans as an option for medical care and not as a last resort.

Thank you very much.

Mr. WENSTRUP. Thank you, Mr. Walker.

[THE PREPARED STATEMENT OF ZACHARY D. WALKER APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Dr. Rogove, you are now recognized for 5 minutes.

#### **STATEMENT OF HERB ROGOVE**

Mr. ROGOVE. Thank you, Acting Chairman Wenstrup and Ranking Member Brownley.

It is a great privilege to be able to appear before the Committee and testify about telemedicine, and, in particular, about the critical role and contribution to the VA telehealth system.

I am a physician and founder of C3O Telemedicine, located in Ojai, California, Ventura County. And when my company was founded, it was founded upon the principle that Americans should

not be penalized for gaining access to health care based upon geography, whether it is rural or inner-city areas.

To that end, we provide acute stroke care through telemedicine to over 30 hospitals across the country, including the great State of California.

Additionally, I have served as the secretary-treasurer on the board of directors for the American Telemedicine Association. And I might mention the current president is General Peake, former VA Secretary.

In January of 2015, Mr. Carl Blake, with the Paralyzed Veterans of America, testified before this very same Committee. And, just to paraphrase him, he stated that the viability of the VA health care system depends upon a fully integrated system so that veterans get the care that they need, when and where they need it, in a user-friendly manner.

I think the VA telehealth program addresses his comments.

For the past 10 years, I have studied many telehealth models and have been most impressed by the VA models, both exemplary and successful.

This past May, I had the privilege of meeting with Dr. David Shulkin, Under Secretary of Health for the VA, at our national meeting. And he provided us with some key elements and statistics that some of you have just mentioned: Over 2 million telehealth encounters, it affected 12 percent of the total VA population; 45 percent of those encounters occurred in rural areas, therefore, precluding them having to waste time to go for a 10-minute visit, which might take 2 hours in both directions. And, more importantly, the outcomes—which in medicine we always want to know what kind of outcomes there were.

In 2015, home telehealth reduced hospital bed days by 58 percent, hospital admissions by 32 percent, and the use of psychiatric beds by 35 percent.

So, looking at the future, the VA telehealth model has a tremendous opportunity to, number one, provide the continued leadership in developing a system-wide telehealth network.

Those of us in the private world of telehealth look at that as an exemplary model and something we should strive for.

We have the opportunity to develop public-private partnerships; particularly as was previously mentioned, the shortage of physicians.

We currently provide as a private company to some major universities around the country to fill in the gap for a shortage of neurologists that universities don't have.

I could see that happening between the VA, companies such as mine and others; major systems like, down the road, UCLA, which is developing a telehealth program, et cetera.

We need to push for CMS to expand reimbursement for telehealth, particularly to metropolitan statistical areas, which essentially is urban areas.

Right now, Medicare laws do not pay for telehealth in urban areas.

Fourth, the establishment and criteria for adequate, accurate, and safe consumer technology that can serve our homebound veterans and patients.

And, finally, something that is really, really important, from my perspective, and that is to deal with the interstate licensing. The VA, the military has the phenomenal ability to have one license to practice in 50 States, just like you have one license to drive from California to New York or Cincinnati.

Right now, it costs over \$600 million to pay for it, exorbitant amount of time, it is a hundred-year-old system that is antiquated. And the State medical boards sometimes may not be looking at the best interest to get programs out and functioning. And, hopefully, we could address that.

So, once again, thank you very much for allowing me to appear before you today.

[THE PREPARED STATEMENT OF HERB ROGOVE, APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, Doctor.

Dr. Galpin, you are now recognized for 5 minutes.

#### **STATEMENT OF KEVIN GALPIN**

Mr. GALPIN. Good morning. Mr. Chairman, Ranking Member Brownley, thank you for the opportunity to discuss the efforts the VA has taken for developing telehealth, the services VA provides to veterans through it, and its expansion.

I am accompanied today by Dr. Scotte R. Hartronft, Chief of Staff at the Greater Los Angeles Healthcare System.

VA is recognized as a pioneer in the practice of telehealth and has used telehealth to substantially increase health care access for veterans.

Since 2002, over 2 million veterans have obtained some of their health care through telehealth services, and the number of veterans utilizing these services continues to grow. In fiscal year 2015, VA conducted over 2 million telehealth visits, serving almost 700,000 veterans.

The mission of VA telehealth services is to provide the right care in the right place at the right time through the effective, economical, and responsible use of health information and telecommunications technologies.

Telehealth changes the location where health care services can be provided, making care accessible to veterans in their local communities, in their homes, and even in their pockets on mobile devices.

Equally critical, it allows services to be delivered from any location, allowing the VA to hire providers in large metropolitan locations in order to serve veterans in areas of provider scarcity. Leveraging telehealth affords the VA an opportunity to increase access, especially for those veterans in rural or underserved areas.

The VA currently offers over 50 types of clinical services through telehealth. Of the services offered through video conferencing, telemental health is the most heavily utilized, and is also an area of strategic growth. For context, more than 2 million mental health visits have been provided to almost 400,000 veterans since 2002.

The VA has found telemental health to be equally effective, if not more so, than in-person appointments. This exemplifies a patient-centered model that efficiently brings mental health care to vet-

erans who might otherwise need to travel significant distances to obtain such care.

In 2016, building on the success of the existing telemental health program, the VA is establishing four regional telemental health clinical resource centers. The goal of these centers is to expand mental health provider services at rural facilities, where recruitment of providers can be challenging. When fully staffed, these resource hubs are projected to provide an additional 65- to 82,000 mental health visits per year at locations of need.

The VA also manages a national telemental health specialty consult center. This center has a virtual clinical team comprised of leading national experts on specific mental health conditions who can be located anywhere in the country.

These providers are able to deliver their specialized mental health consultation services to locations in the country—to any locations in the country to assist veterans with the most complex conditions. This center has delivered services to over 4,600 veterans at over 120 locations.

The VA continuously adds new telehealth specialties and services as technology improves. For example, teleintensive care is a telemedicine program that links intensive care units in VA medical centers to a central monitoring hub staffed with intensivist physicians and experienced critical care nurses.

Through the use of cameras mounted above each patient's bed, along with links to the medical record and vital sign monitors, staff in the tele-ICU hub not only see all the pertinent medical data on a patient, but they are capable of performing audio-visual exams; discussing treatment plans with patients, nurses, and families; intervening during emergencies; and generally providing specialist-level care and consultation to the local staff.

Tele-ICU does not replace the local ICU care team, but adds specialist resources and another set of expert eyes to watch over our most critically ill veterans.

Looking forward, the VA is excited to expand the teleprimary care model, similar to telemental health, that will bring virtual primary care providers, social workers, psychologists, and pharmacists into rural sites where needed.

The VA is also developing the VA Video Connect application, which can provide a fast, easy, encrypted realtime video connection between a veteran's personal mobile device and computer and a provider.

The VA recognizes we are still at the beginning of our journey to best leverage our integrated national health care system and remote care technologies.

The VA would be able to accelerate this expansion and leverage new opportunities if our clinical and technical capabilities to deliver outstanding health care through virtual technologies were unambiguously supported by legal authority to deliver clinical services, irrespective of the veteran or the provider's location.

The VA is a leader in providing telehealth services, which remains a critical strategy in ensuring veterans can access health care when and where they need it. With the support of Congress, we have an opportunity to shape the future and ensure that VA is

leveraging cutting-edge technology to provide convenient, accessible, high quality care to all veterans.

Mr. Chairman, this concludes my testimony. Thank you for the opportunity to testify before the Committee today. We appreciate your support, and look forward to responding to any questions you and Members of the Committee may have.

[THE PREPARED STATEMENT OF KEVIN GALPIN APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, Doctor.

Mr. WENSTRUP. Dr. Hartronft, you are now recognized for 5 minutes.

#### **STATEMENT OF SCOTTE HARTRONFT**

Mr. HARTRONFT. Good morning, Mr. Chairman and Ranking Member Brownley.

Thank you for the opportunity to discuss the efforts that GLA has taken to develop, deploy, and expand telehealth. In fiscal year 2015, GLA provided 20,000 health visits to over 6,000 veterans.

GLA uses all telehealth-related modalities to include clinical video telehealth, Store-and-Forward technology, and home telehealth.

Clinical video telehealth involves a clinical provider and a patient interacting via video telecommunications, such as telemental health, while Store-and-Forward technology takes digital images that can be reviewed remotely by specialists, such as things like diabetic retinas being examined by an eye specialist, or a suspicious looking mole by a dermatologist.

And then, lastly, the home telehealth, which allows prompting and monitoring for chronic diseases, such as diabetes.

GLA currently has 34 different clinics available that range from audiology to mental health. At the Oxnard CBOC, we currently have seven different telehealth clinics, which include different types of mental health clinics, such as general mental health, PTSD, compensation and pension, and others.

A major focus at GLA is to improve access for our veterans, and the use of the telehealth services is one way to help do that.

One example is, in May, GLA began a pilot primary care program at the Oxnard CBOC. Since GLA did not have a teleprimary care program at the time, this pilot was set up specifically to help address the primary care access demand at the Oxnard CBOC.

This pilot was not to replace traditional face-to-face primary care provided at the CBOC, but as a supplement, while additional needed primary care staff were being recruited and hired.

Due to the pilot success in improving access to primary care at Oxnard, GLA has made arrangements to continue providing teleprimary care services until the traditional primary care clinical access reaches a stable and improved state, and provide another option for veterans based on their preferences.

Another example of how telehealth programs can improve, as previously testified, is the chronic disease states that we use with the home telehealth.

And veterans enrolled in home telehealth in fiscal year 2016 have had a decrease in hospital admissions 6 months after being

enrolled, when compared to how often they were requiring hospital admission before enrollment.

GLA is currently reviewing the demand for telehealth as well as face-to-face services and implementing action plans to continue improving access.

Specifically, for the Oxnard CBOC, GLA has recently added tele-audiology and a face-to-face audiology technician to help with hearing aids.

Additional face-to-face specialty care services are scheduled to begin soon at the Oxnard CBOC to include cardiology, cardiac echocardiography, this month, in August; gastroenterology in September; and physical therapy in October.

In conclusion, telehealth will not completely replace the traditional face-to-face clinical care. But GLA is adding additional telehealth resources to improve access to care for veterans by supplementing traditional face-to-face clinical care, when, to whom, and where appropriate.

Mr. Chairman and Ranking Member Brownley, this concludes my testimony. Thank you for the opportunity to testify before the Committee today, and we appreciate your support. I look forward to responding to any questions you or others may have. Thank you.

[THE PREPARED STATEMENT OF SCOTTE HARTRONFT APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you all very much.

At this time, I am going to yield myself 5 minutes for questions.

I want to start with you, Mr. Walker. You mentioned that it was—telemedicine was offered as a last resort.

Mr. WALKER. Correct.

Mr. WENSTRUP. Could you expound on that a little bit?

And what would you say to veterans who are becoming aware of telemedicine as a possible choice for a method of care?

Mr. WALKER. I say, when I spoke on it being a last resort, I have used health care since I got discharged from the military in 1979 up to my—this last episode. And I had never been introduced to the thought of telemedicine.

I think it was through my frustration and my pushing to get some adequate care that it was presented to me as a last resort, not as an option.

Maybe if it was presented to me early on in the process when I was given the 2-month timeframe to see a doctor, it might have been a more positive result. But me pushing, then it was, like, a last resort.

I say for any veteran that may be going in there for normal testing—the doctor spoke of diabetes—any related tests that you normally go through and you want the results, and you want the results in a timely manner, that is a good option.

Any kind of medical condition that doesn't necessarily preclude a doctor actually putting hands onto you, I think, is an outstanding idea. I am glad it was introduced to the VA.

Mr. WENSTRUP. Thank you.

So in that context about him feeling as a last resort, as this is developing and growing, my question for Dr. Galpin, if you would talk about expanding telemedicine throughout the VA system, what

kind of an algorithm do you anticipate? Is there one in place? Should we put one in place for that being an option? Rather than, Hey, you know what? We got somebody on the phone who is kind of upset their appointment got cancelled. Let's throw that at them.

Is this going to be part of an algorithm that is an option up front for people? And what does that look like? And will that be sort of about VISN to VISN or national program?

Mr. GALPIN. I appreciate that question. So right now, it is actually very much part of our strategic plan to help develop the capacity of telehealth. And so, we have discussed a little bit our telemental health hubs and the teleprimary care hubs we want to develop.

Those hubs will serve as essentially an interim staffing program for facilities. So if a provider leaves and a veteran is left without a primary care provider, or without the resources of a mental health provider, we will have resource centers that can help out and fill in on those staffing levels.

So that is kind of regional level and the type of help we can provide to each other across an integrated health care systems like the VA.

In addition, I mean, we want to see telehealth being used on a day-to-day basis in the regular practice of medicine. So when a veteran comes into a clinic and they need a retinal screening, we want to make sure we have that option available. We want to make sure we have the dermatology option available in every clinic. Doesn't necessarily have to all be through telehealth.

But we have the capability now of offering services in a standard way across the board at convenient locations that we didn't have before. So we want to integrate those practices, and really take advantage of that.

Mr. WENSTRUP. Well, the question I have, though, is, if someone calls for an appointment and they are being told, you know what, you can be seen in 3 weeks, you know, here at the VA.

When they make that initial call for an appointment, might they not be given that option right off the bat? Is what I am asking.

Mr. GALPIN. I think if the services are available, I think that is the key question.

So at this point, we are still expanding our telemedicine programs. And we have a lot to do. We are still at the beginning of a journey. This is one of those areas that we are seeking help from Congress so we can more rapidly increase our program.

If the services are available, then we have the opportunity to leverage those services for the individual patient when they call in. We first have to get to the point where they are available, and we have that resource-sharing capability.

Mr. WENSTRUP. So, and let me go to you for a second, Dr. Rogove, when you are talking about the licensure across States and things like that.

Because, currently, to be a provider at a VA or Federal facility, you just need a State license. And then you apply and credential, as you normally would.

So if someone is in a different State, but they are credentialed to the VA, is there a barrier for someone in Ohio to take care of



someone in California via telemedicine if they are credentialed with the VA in some way?

Mr. ROGOVE. Specifically the VA?

Mr. WENSTRUP. Yes. Particular to a Federal agency.

Mr. ROGOVE. My understanding is, yes, they have that capability of being a physician licensed in one, and taking care of a patient in another State.

Mr. WENSTRUP. If you have gone and credentialed through the VA itself.

Mr. ROGOVE. Correct.

Mr. WENSTRUP. So there is an option to be able to do that.

Mr. ROGOVE. Yes. That is my understanding.

Mr. WENSTRUP. You want to say something, Dr. Galpin, on that?

Mr. GALPIN. Yes. This is actually what we are seeking from Congress on this. Is that actually the laws are somewhat ambiguous in this area. And it is one of our major barriers to being able to expand services quickly.

So, you are correct. If I have a license to practice in a State, and I am licensed in Georgia, I can go to a VA facility and I can provide care at that facility for veterans.

It gets ambiguous when you take that provider outside of VA property, where you take care of the patient outside of VA property.

So if you look at the way we want to leverage to this type of technology, we can overcome space barriers and use alternate work sites, and set up providers quickly in their homes without having to build new spaces, or take care of veterans in their homes, or as they are on their mobile devices, going across country, it is not clear.

So that is really what we are seeking, is an unambiguous law that says VA providers, irrespective of our location or the veteran's location, can take care of our patients.

That is our major ask.

Mr. WENSTRUP. Sounds like you are seeking some—seeking for us to codify this to some degree. And say, look—because I have always felt, and especially as we put Choice in place, you can be a VA doctor; you don't have to be within those walls of the VA.

So if you are a VA doctor in Ohio that participates in the telemedicine program, whether you ever go within the walls of the VA, but you are credentialed by the VA, that you can do that anywhere in the country for one of our veterans.

Am I on track with what you are seeking to clarify that or make that available?

Mr. GALPIN. That is what we are looking for. Again, I want to be able to provide care, regardless of my location, regardless of the veteran's location.

And it is—you know, we are looking for, I think, a pretty straightforward legislation that gives us that authority that we essentially have within our own buildings. We need that within legislation.

Mr. WENSTRUP. Got you.

I now yield to Ms. Brownley.

I am sorry.

Did you want to add something to that?

Mr. ROGOVE. Yes. Just briefly.

It is interesting, CMS just released the fee schedule for 2017. And in it they are redefining who are the telehealth—

The way you look at telehealth, there is the originating site, which is the hospital that is requesting where the patient is, and then there is the distance site, which is where the telehealth doctor is.

The way it works right now is, it is the patient centered, which means you are crossing State boundaries and need a license.

However, what CMS is now proposing is that it is based on the distance site where the physician is. In other words, that physician in California could take care of a VA patient whether it is at their home or in the VA hospital in the State of Ohio.

So this is something that is—the proposal was just released a couple weeks ago. And this will change the game a bit and maybe give us some leverage.

Ms. BROWNLEY. That is very new information that I wasn't aware of.

I just wanted to follow-up with Mr. Galpin on the line of questioning, though, in terms of solutions for expansion of these resources.

Is it that simple really just to pass a piece of legislation that says you can do it? Or is it more complex and interwoven with all of the various States and their licensing and so forth and so on?

So, you know, it sounds to me like what you are expressing is something that is, you know, pretty simple.

I served in the State Legislature in California. And, boy, scope of practices issues where, oh, my goodness, you would pass a Committee room and that is where you had 50 people standing in line to testify in the Committee.

So I just want to make sure that it is something as straightforward and relatively simple to resolve this issue.

Mr. GALPIN. Yes. I would say, I think with pretty simple clarity, I do think it is a simple solution from a legislative standpoint.

As a lot of people already assume, there is kind of an understanding or belief that the VA already has this express authority.

And, again, it is ambiguous. We, in some people's eyes, have the authority, but it is not codified. We can't point to legislature and say, Listen, we can do this.

And so when we want to set up telemedicine hubs and move providers from where we have relative abundance, to where we have relative scarcity becomes this large legal question. And really slows us down. And in some cases, it hampers us from moving forward quickly.

So, yes, I think there is a fairly simple solution that can be provided that will significantly help us expand.

Ms. BROWNLEY. When we are seeking providers in a network—here it is TriWest. So they are sought out and approved based on the standard within VA. That is the one central standard that is across the board nationally. That is correct; right?

Mr. GALPIN. Can you clarify the question on that.

Ms. BROWNLEY. So as we recruit providers to—for the Choice program, for example, for veterans to be able to use doctors in their communities rather than the VA, if—you know, based on the cri-

teria now as—you know, if you can't get an appointment within 30 days and the 40-mile rule, although all of our veterans here know that the 40-mile rule doesn't apply to us here in the county. We keep trying to fix that. But we haven't achieved that yet.

So all I am saying, is that when they are recruited to be community providers for the VA, are they approved by the VA by the same standard by which you approve doctors within the VA?

Mr. GALPIN. Okay. So one piece I just need to clarify. So when we are talking about our telemedicine program, we are actually talking about providers that are hired or work directly with VA.

Ms. BROWNLEY. Correct.

Mr. GALPIN. So we bring them into our system. We go through the same process to credential and privilege them. They have to be credentialed and privileged at a VA facility. So they go through the same standard.

Plus, then they get additional training to become telemedicine providers so they can serve in that capacity.

So, yes, the standards—I mean, that is the foundation of our program, to make sure we can provide quality services—

Ms. BROWNLEY. So you are not talking about expanding telehealth to our community partners?

Mr. GALPIN. No. I am talking about the authority for VA providers to provide services to veterans.

Ms. BROWNLEY. Okay. All right. Very good.

So I wanted to go back, you know, to our CBOC here in Oxnard and serving our Ventura County veterans.

So if you could describe to me, Dr. Hartronft, exactly—my understanding is—there is sort of three pillars of telehealth services. And if you could describe to me, are all three of those pillars embedded into the Oxnard CBOC or are we not there yet?

Mr. HARTRONFT. Yes. All three are currently available at the CBOC. The CVT, which is the clinical video teleconferencing; the Store-and-Forward, which is teleretinal; and then also with the home telehealth, which are the monitors that people have at home that remind them, with the chronic disease.

Ms. BROWNLEY. So the Store-and-Forward telehealth is there?

Mr. HARTRONFT. Yes.

Ms. BROWNLEY. And Store-and-Forward telehealth, how does that synchronize with electronic medical records? Once you have that data, is it merged into, permanently into the record of the veteran?

Mr. HARTRONFT. That is the nice part, is— it does merge into a part of CPRS where it can be viewed, and then notes taken by the reviewer at the remote site directly into the records.

And that is, you know, not having to send slides off to a far, distant university that sometimes people have to do. This could be realtime, literally the next day, where it arrives, the person reads it, and it goes right into the record and available for the provider to see the next day.

So it is really, a very timely modality when one thinks of the traditional means of sending out, that most facilities do if they don't offer in-house services.

Ms. BROWNLEY. Very good.

My time is up. I will yield back.

Mr. WENSTRUP. Then we will go another round.

Ms. BROWNLEY. Sure.

Mr. WENSTRUP. Dr. Rogove, if I can get from you your opinion on how we can better partner telemedicine practices like yours and increase the availability of telemedicine to the VA.

Mr. ROGOVE. Yes. I think one of the examples I mentioned, briefly alluded to, was the fact that the capacity is really important right now for health systems. And I think you have physicians, let's say, in an academic medical center or VA system where they have responsibilities, on-site responsibilities, clinic responsibilities, education responsibilities, and now you are adding on telehealth responsibilities. There is so much you could get out of the physicians to do that.

And it is predicted that we are going to be, by the year 2025, we will probably be 90-, 95,000 physicians short. A little bit less than we thought.

So in an effort to do that, I think this is where the public-private partnership comes in. Universities used to be in one silo, the VA is in another silo, and there is private enterprise in another silo.

If certain facilities have the capacity to help another facility or system, I think now is the time that we start to do that.

Our case in point is that we just got a big contract in northern New Jersey. It is two academic medical centers together with a bunch of rural and community hospitals. And they just don't have the capacity for their physicians, their neurologists, in particular, for stroke. And they have solicited us to come in there and help solve the problem.

And while we are not physically present, we helped to augment their practice. And, euphemistically, I say it is like having a partner without having to provide a 401K for. They are here to help you and do what's necessary: Night call, weekend call, vacation call. To help alleviate the burden and prevent more burnout.

So I think there is a tremendous opportunity and drop the barriers between academic, government, and private, and bring us all together and find out where the resources are, and re-deploy them.

Mr. WENSTRUP. Ultimately, our goal is to get care to our patients.

Mr. ROGOVE. Correct.

Mr. WENSTRUP. And in some ways, as references, get help from Congress or get Congress to get out of the way and let those things happen.

Dr. Galpin, credentialing process. This is always an issue, even at the CBOCs. You lose a doctor, and you try to replace them. You may even have a VA doc from somewhere else who wants to come to your CBOC. And he has got, you know, several months' credentialing process to go through. Rather than being able to just say, Look, I already work at this CBOC over here. Why can't I just come in and start working there?

But the credentialing process for telemedicine, for example, how is that operating? And are there any—any flies in the ointment there that you want to address?

Mr. GALPIN. So credentialing/privileging, of course, is a foundation, one of the key ways that we maintain quality services.

We have the authority within our integrated health care system, which is really key for us to being able to do this efficiently, to share privileging—share privileging decisions from one facility to another under joint commission.

So if I am privileged at the Atlanta VA, and I want to work through telemedicine at another VA facility anywhere in the country, the other facility does not need to go through all the primary resource verification that takes a tremendous amount of time. But they can develop an agreement that essentially says, yes, we can trust another facility, that they are utilizing the processes they are expected to be utilizing under the joint commission, and VA policy to do the right thing. And so we accept this provider as a provider that can provide services to our patients.

As a piece of that, then, that provider needs to be monitored, there needs to be a bidirectional exchange of information between those facilities to make sure that the provider is competently performing their privileges after the fact.

But that is a process that makes it easier to move resources from one place to another.

Mr. WENSTRUP. I appreciate that.

Mr. Walker, I have a question for you: When is the next appointment with the VA?

Mr. WALKER. Presently, I don't have one scheduled.

Mr. WENSTRUP. Okay.

Mr. WALKER. I am going through process of the referral that the doctor made for me. So not with my primary care clinic. But I do have one in the Valley, off Plummer.

Mr. WENSTRUP. Do you plan on your next primary care visit to be through telemedicine unless you feel a need to be physically examined?

Mr. WALKER. I am not sure. I was told later that my primary care physician retired. And that I have—I do not at the present time have one assigned to me.

Mr. WENSTRUP. Okay.

Mr. WALKER. So we will move forward, and hopefully it will go a lot smoother transition than the last.

Mr. WENSTRUP. Thank you.

I yield to you, Ms. Brownley.

Ms. BROWNLEY. Thank you. And I want to again sort of harken back a little bit to the Oxnard CBOC.

Because I know there are many veterans here in the room who utilize that facility. So I want to be as transparent, so everyone in this room knows that we have gone through some growing pains at the Oxnard CBOC. We have expanded the physical footprint of the CBOC. And once we did that, then we were understaffed for a while.

And now I think we are at a point where we are now fully staffed and beginning to expand some specialty services at the CBOC.

So we are just sort of getting there in terms of a larger space and fully staffed.

And I think that, you know, telehealth is going to be a critical component in the services that our CBOC can offer.

But I want to be clear that, you know, if our veterans are calling up for appointments, are coming into the CBOC for an appoint-

ment, I think at this particular point most of our veterans are expecting that they are going to see a doctor, and there is not going to be another course or avenue for them to go down.

So, you know, it is the educational component here. I want veterans to understand that if they want to see a primary care doctor in the CBOC, they can see a primary care doctor in the CBOC. I don't want them to think we are talking about all of this to substitute the traditional doctor-patient relationship and those visits.

But I do think, and certainly based on Mr. Walker's testimony, that there is a large learning curve that is going to take place.

I think probably some of our older veterans are going to be a little leery about using technology around their health, because that is a new concept for them. I think our younger veterans might be more susceptible to it and open to it.

I think once we understand how telehealth can augment their health care services, and particularly to understand that this could eliminate those follow-up travels to Sepulveda or West L.A., that that can be done in the CBOC, seeing a doctor face-to-face, and perhaps even your doctor sitting with you in the examination room.

I think people then, you know, their sort of fears and misunderstandings about what this all is, can be alleviated and helped.

So I just want to understand. And for everyone who is here today listening, and I think almost everyone in the audience here today is here because of their positive or not-so-positive experiences within the CBOC.

So if you could, you know, just kind of walk us through a new patient who has never been in the CBOC before, and what their experience might look like. And the experience of a veteran who comes into the CBOC, has been seen by a primary physician, who may have diabetes or who may have heart issues. And explain, you know, what the procedures might be in those two pathways.

Mr. HARTONFT. Okay. First of all, I would like to apologize to Mr. Walker for his experience with his first introduction to telehealth.

Just to give a history of the health introduction at the CBOC, I arrived as the new chief of staff on April 4th, and noticed the demand was exceeding our supply currently. And by May 8th, we were starting to see our first patient with teleprimary care.

The problem with forward deployment in a rapid fashion of 4 to 5 weeks is, again, that education curve was something we definitely—again, that is the area I would like to apologize for. Because it is definitely something that gets another preference, is the choice, it is not going to fit everyone. But it also was, again, giving them another choice to base that on.

So that is kind of how we rolled that out, as to seeing that. Because, as you can imagine, how much longer it takes to bring on other providers through the process, where one can see the problem after being here just a couple weeks, and then within 2 or 3 weeks actually having the first patient being seen by teleprimary care.

Actually, for a new veteran, if they are coming into our system, as we are rolling out the education curve, is giving them, again, the—explaining the process to veterans as they are coming on as a new patient. Just saying, What are your preferences? We have

options. To include your face-to-face visit or a teleprimary care visit.

And then they would actually be able to—our goal is to get that to where they can choose one of those on their preference. Especially while—as we are building our capacity at the current clinic.

So we definitely never want to replace face-to-face interaction with primary care. That is not our goal. But our goal is to give another option as we are bringing on the capacity.

The nice thing is that we are adding peripheral devices, as we call it, to where they can actually have more interaction with a physician with, like, a stethoscope that the tech on their side of the patient can actually put to the chest of veteran. It can be heard well by someone remotely, and other devices, so that they can do more of a contact physical exam.

Largely, for the veteran, as they come in, it will be preference choice as to which they prefer. And then some of it could be, again, that option based on what may be available sooner until we get all the panels fully expanded.

Ms. BROWNLEY. And so when a patient comes into the CBOC and has an appointment, then in terms of follow-up, are the—are the medical teams that are set up at the CBOC, are they trained to say, rather than you having to go—I need you to have these tests. But rather than going—having the tests, but then not having to go back to go West L.A. or Sepulveda, we are going to—if you were willing, we will—you know, we can have that follow-up meeting here in the CBOC through our technology, and you'll be able to see the doctor that you might have seen. Or, you know, at least see the doctor or the specialist who can give you the results of these tests?

Mr. HARTRONFT. Yes. And also one of the choices, a veteran may start off with a telehealth provider through teleprimary care. But then we would like to give the option even at some point, if they want to change over to an in-person, face-to-face.

So that is one of the things that we would definitely like to focus on is to—

And then we train, with the techs that—we have expanded resources to where techs on each side are being able to better walk the veterans through the process, as Mr. Walker explained, about bringing them back, doing their assessment by the nurse, and bringing them in.

So, again, we are in that—teleprimary care was a new event, new program, especially at the Oxnard program. So we are definitely trying to—

Ms. BROWNLEY. And continuity of care. I know that that is an issue that veterans, you know, are very concerned about. If they—if they have a health issue, they are interested in seeing the same physician, you know, over the course of a treatment.

So how do you get that continuity of care through telehealth?

Mr. HARTRONFT. Again, I think a lot of that is just the comfort and preference of the veteran. As to—if they don't mind seeing a secondary provider, if they can't be worked into their doctor's schedule same day.

A lot of times, as we have seen in private practice, sometimes you can see a provider, an extended provider, the same day.

But they work with your provider and have the same record.

So our goal is to—even the veterans who start off with teleprimary care, the option eventually would be to go to more of the face-to-face model, unless their preference is to strictly stay with teleprimary care.

The nice thing, though, is with our electronic records and our ability to have all the—you know, the information right there in front us, unlike many closed systems in the private sector, it is really a lot more streamlined as to handoffs with patients.

So a lot of it is really—we would like to make it somewhat they choose, as to, I don't want to make a template, one size fits all. I would really like to have these decision trees based on their preferences and choices. So it is kind of hard to describe what it would be for every veteran.

Ms. BROWNLEY. Thank you.

Mr. WENSTRUP. You just touched on one of the things that I wanted to talk about. Which is making this type of an option, the decision between the doctor and the patient on how they choose to proceed.

And, in my practice—you know, I started practice in 1986. And, you know, in later years, I would have a patient call—I treated a lot of diabetics. They have wounds, they have ulcers. They are worried: Is it infected? And this and that.

And I could get on the phone and say, Take a picture of it. You know, let me just see it.

It might save them a trip in. Because it looks fine. Or, yes, I might need to put you on an antibiotic. And then I will schedule for your follow-up in a couple days.

So there is a lot of advantages that save time and money, and really provide better care. Because you have that instant access, rather than—especially somebody who is homebound. You know, what a huge advantage these things can be. And in a simple way.

I would like to hear from, really, all of you. Because my feeling, in the ideal situation for the VA or for any—for any health care system whatsoever, that everyone has a primary care doctor.

And this is one of the things in my district that I saw was of huge value at the CBOC. You know, I would go out in the lobby, and I would talk to the patients out there. And they love it. They love it because that is my doctor, I know who it is, I know this person.

Rather than, I am going to the VA. I don't know who I am going for see today. You know, who will be there. It is a different one than I saw last time.

It happens in every practice.

But, nonetheless, they feel like they have got someone where there is a relationship and some ownership. And so whether it is through telemedicine or through the face-to-face visit, you have that opportunity.

And the other thing that I would like to see, and maybe have you comment on, referral decisions should be between that primary care doctor and the patient only. We don't need another layer of bureaucracy.

If you are hiring primary care doctors and you credential them, you must trust them to make decisions and the patients to make decisions with them.



And that to me is one of the things that we are tying people up in bureaucracy when it is time to move someone over.

And I think you—you somewhat commented on, Mr. Walker, where you said “my doctor retired.”

Mr. WALKER. Yes.

Mr. WENSTRUP. So I would imagine that you are very interested in meeting your next primary care doctor.

Mr. WALKER. I would like to, yes.

Mr. WENSTRUP. Okay. But comment on those other aspects, if you would. Go down the line.

Mr. GALPIN. So I—my background is internal medicine, clinical informatics. But I work as a primary care provider in the VA.

And I agree with you. I think it is very important to have that one provider who is recognized as the face of the VA for the patient, who coordinates their care.

I mentioned the teleprimary care hubs. This model where we can provide interim staffing. What I really love about this program is that they commit a provider to work with a panel of patients.

So, again, if your provider retires, and we have the option to bring in a provider, they commit to at least 6 months for that provider to take over that patient panel. So it is at least the same telemedicine provider until they can hire the new provider in the clinic. So you do get continuity.

In addition, we have more than just the capability of bringing the provider in, but they have psychologists and social workers and pharmacists.

So they can bring, actually, other members of the PACT team to some of the rural sites that may not have those resources. So it functions as a very effective interim staffing program.

In addition, we try and hire those providers somewhat regionally located to where they are going to be delivering services.

So even though their primary focus is on delivering teleprimary care, they do travel to those centers 1 week, at least, out of every quarter to provide some in-person appointments for veterans who may not be interested in having their care through virtual means.

So we are really excited about these programs. We are really just getting started on setting up that model. But I think it is a very exciting model. And it helped me overcome some of the barriers that I personally had as a former primary care provider of how would this all work and will it fit—fit all of our needs.

So very exciting. But I think it helps address some of the questions you have.

Mr. WENSTRUP. Thank you.

Doctor, do you have anything else to add?

Mr. HARTRONFT. No. I completely agree with that.

In addition to—the nice thing with telehealth is, even when someone has their established provider, the other modalities, the Store-and-Forward, they can potentially have the dermatologist help the primary care provider decide, like with teledermatology, whether that—you know, a suspicious lesion should be removed.

And then also the home telehealth, which is very nice with chronic diseases, and provides better information for the—more data points for the primary care provider to base longer term deci-

sions over, instead of single-point blood pressures when they come into the clinic, per se, or blood sugar.

So the nice thing is you can—even if you are not in the tele CVT program, where you are face to face, the primary care doc can actually use the other modalities to expand their care to others.

Mr. WENSTRUP. Thank you.

Ms. Brownley.

Ms. BROWNLEY. Yes. Thank you.

I have a question.

So Dr. Galpin, I—my staff made me actually aware of a report from the Commonwealth Fund which noted that patients who used VHA telehealth services between 2003 and 2007, that 96 percent were male and 4 percent were female.

I was wondering if you can add something to that data point.

Mr. GALPIN. Yes. So we looked at that information, looking at our most recent fiscal year, so fiscal year 2015.

And we have about 7.4 percent of our veteran population being served in the VA. Our female veterans. And about the same proportion use telehealth services. So if you look at all the encounters, it is about 7.2 to 7.4 percent for our clinic-based telehealth programs and Store-and Forward programs. Similar to home telehealth model.

So it is a program that is utilized by female veterans. I think at about the consistent rate as with our male veterans. We have also got some programs that are uniquely geared toward female veterans.

So we have a—there is actually a fairly long list, but women's health primary care, we have a women's health stress disorder clinic, OB/GYN.

And actually as of last week, we just signed a women's telehealth operations manual that will help facilities set up these programs, provide the guidelines, and basically how to get started.

So it is certainly an area of focus. There is a lot of great opportunities in there, and I think we are beginning to really take advantage of those.

Ms. BROWNLEY. Very good.

In your testimony, at least in your written testimony, you kind of describe these sort of three pillars of telehealth.

And is it fair to say that all three of those pillars are available throughout the country at every clinic across the country, every medical center across the country? Is that where we are in terms of scale?

Mr. GALPIN. So, yes. That is—I will have to spend a little bit of time on this question.

So, yes, the three general pillars are generally available across the country. People have clinical video telehealth services, and they have Store-and-Forward telehealth services, and home telehealth services.

From one location to another, though, the facilities may have chosen to invest in different types of offerings through those services.

So you can't say, for instance, that every CBOC, every community-based clinic is going to have a dermatology program, or teleretinal program, or this type of program.

So the variety of the clinic is still a local decision. Based on what—what are the needs at that facility or can that facility safely offer, you know, what is the decision of the medical executive committee, and what are the needs of the veterans in those locations.

So, again, in general, yes, they are available pretty ubiquitously around the country. However, any individual offering, it is hard to say that is available at every location.

Ms. BROWNLEY. And are rural areas using it more than urban areas? Or is it, you know, pretty consistent or inconsistent across the country?

Mr. GALPIN. Last year, in fiscal year 2015, we had about 45 percent of our encounters were for veterans living in rural areas. So it is pretty split.

I mean, there is a lot of advantages to doing it both in rural and urban communities.

Ms. BROWNLEY. Very good.

And I think, Dr. Hartronft, you talked about—I think it was you that talked about sort of consultation services? These are specialists?

Mr. HARTRONFT. Yes.

Ms. BROWNLEY. And so are those services, or hubs is sort of the way I am thinking about them, specialty hubs, are they across the country? Do we have one in West Los Angeles?

Mr. HARTRONFT. We have kind of taken an approach with the new leadership of being data-driven and being strategic. In the sense of what we have done is, the veterans that we currently are looking at that drive to West L.A. or Sepulveda from Oxnard, we have looked at what type of services are requiring them to do so. And those are the ones that we are focusing on primarily first, whether it be face to face, and why we chose some of the programs we have.

And then what we do is, based on that demand and how many we calculate would be during a week, to save efficiency with that provider in our grids, we have used—decide whether the telehealth would be—provide enough.

And so we are kind of using both the face-to-face driven on supply, demand, and how we are seeing our current veterans having to make that trip. It is kind of how we are rolling it out.

We are wanting to—I think we will look a lot different down the road.

But, right now, how we are choosing is just based off of what we are seeing, the veterans from Ventura County having to make that drive to Sepulveda or West Los Angeles.

Ms. BROWNLEY. Very good.

It seems to me that, you know, we have Dr. Rogove here, who is really trying to push the envelope in terms of private health care delivery. And he has barriers that the VA doesn't. That the VA doesn't have.

And I think it is fair to say that the VA has been a leader in telehealth.

And, you know, I think the VA has a large responsibility to keep pushing, you know, and pushing that envelope.

Because if we are successful within the VA providing these services and proving, really, to the rest of the world that this is indeed

the future, and the way—the most efficient way to provide services, most likely, and certainly in terms of physician shortages and so forth.

And so I think we have a big responsibility to work not only with private industry and work with some of their issues, but we have a responsibility to be the trend leader here and to push the envelope.

And so I think, you know, I am certainly more interested in, you know, how we—you know, to the degree that—you know, we can continue to kind of keep pushing and pushing and pushing on this.

Particularly when, you know, I think about specialty care and for those veterans who have a particular kind of illness or an unusual illness where we really need expertise from, you know, across the country, or a brain surgeon that there is only three in the country that perform this particular kind of surgery.

And that we are really continuing to really push, push, push.

When I first was elected, I mean, I knew very quickly that we were providing mental health through—mental health services through telehealth.

And for some veterans, that is wonderful. They can be in the privacy of their own home; they could come to an office and wait in a waiting room, and they feel more comfortable using telehealth for their mental health services.

And to the degree that we can get more veterans utilizing our mental health services who need it, that is a good thing.

So, you know, I want that. But I also want to really be kind of pushing, you know, pushing on the edges.

So that we can kind of break barriers, really, for—and—and as we try to do in the Choice Act, to bring community partners with the VA, that we can do—be community partners within the telehealth arena as well.

And so, you know, I am certainly interested in following up and making sure that we are overseeing, you know, the data on this and overseeing how we are pushing the envelope on this.

And I will bring that down to another level entirely, and that is the local level here, making sure that we are—the education and so forth, that I think needs to take place at the CBOC is there so that people know more of their options.

But, you know, in terms of where we might be scaling, it sounds like we have scaled up, you know, across the country. Different regions are using it differently. But that the hardware, so to speak, the equipment that one needs to be able to provide these services, seem to be—you are telling me that they really are—they exist, you know, across the country.

And so I will just be interested in the future to see, you know, where we are really kind of pushing that envelope further, and where we can be better partners as in the private health care delivery as well.

Mr. WENSTRUP. Thank you.

I have one more quick question.

Do you measure wait times for telemedicine?

Mr. GALPIN. So not specifically for telemedicine.

I have some internal data from one of our programs. I just know because I look at data one of our dermatology programs. We are

looking at. A very exciting program, serving a lot of veterans with dermatology.

And they are able to turn around an image and a consultation in one day, on average, when they look at their 12-month averages and average them.

So there is certainly some exciting areas where, you know, the wait times can be reduced.

But we don't separate out the services we provide through telemedicine. I mean, the wait time for the veteran is still the wait time. And telemedicine is one of our services. So the key is, did we get the veteran into service, regardless of what modality we used.

So we don't have—I mean, there may be individual programs doing it, but at a national level, that is not something I am tracking. There is just the wait time.

Mr. WENSTRUP. That may be something we want to look at.

As we move forward, obviously, you know, this is exciting, this is new, this is growing. And, you know, through that process, no matter what it is, you are always looking for what becomes the best practice. And that is the work in progress. Right?

And so I don't think either of us or many people in our audience anticipate that you've got it all down right from the get-go. Because it is growing and it is changing. And you've got to also educate patients on the opportunity as well. So it is a mixed bag.

And I think the other thing too that you've—is in implementing this, let's make sure you have the flexibility to do the things that you want to do to provide care, and we don't box ourselves in to some type of protocol that may end up doing more harm than good sometimes. We want to have the flexibility to make decisions on behalf of the patients.

So a couple take-aways have to do with the credentialing and the licensing questions that may exist. And I think that that may be something we can work on.

Ms. BROWNLEY. Yes.

Mr. WENSTRUP. And work with you on that to try and make it very clear as to how this is done.

One thing that crossed my mind is, no matter where the doc is, virtually, he is in the VA or she is in the VA, right? And no matter where the patient is, they are in the same State as the doctor that they are working with.

So maybe we take that concept and apply it to the licensing and be able to take away that burden and make it more flexible, and more opportunities for you.

But if there is no further questions, the panel is now excused.

And I want to thank you all for being here. I think you all had wonderful input for us. And, again, thank you.

And I want to thank the members of the audience for being here today as well. It has been a pleasure for me to come to sunny California and be with all of you. Hopefully, I won't have any problems on my flight back.

With that, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks, and include extraneous material. Without objection, so ordered. The hearing is now adjourned. Thank you.

[Whereupon, at 10:23 a.m., the Subcommittee was adjourned.]

## A P P E N D I X

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### Prepared Statement of Zachary D. Walker

Good Morning,

I am Zachary Walker, a veteran of the United States Navy from 1975 to 1979. My introduction to Telemedicine was presented to me by my Veteran's Administration (V.A.) medical clinic, not as an option, but as a last resort. My journey began when I received a phone call from my local V.A. clinic one day before my scheduled appointment that my appointment was canceled. The clinic informed me that my health care provider was not available. I was told the next available appointment would be in two months. Having already waited two months for an appointment, I requested to see the next available health care provider. Again, I was informed that the wait time would be two months because they were booked. I took the next available appointment; now having to wait four months to see a provider. I terminated the call feeling frustrated and angry that my health care was being jeopardized due to a backlog in the system.

The next week, I called the V.A. clinic and asked to speak to the supervisor who was not available. I then provided my information for a return call. Not having received a return call for two days, I again called and spoke with a supervisor at the clinic. I reiterated my story, but it was apparent that she was unable and unwilling to help. She gave me some unclear information about how to proceed if my condition worsened, which I felt was not a solution to my problem. Out of desperation, I called my local V.A. representative and explained my situation. To my surprise, I received a call the next day from a clinic nurse, who presented the option of telemedicine. Initially, I was reluctant because being seen by a doctor through a monitor was counterproductive to any medical experience I have had in the past.

The nurse was through explaining the process and assured me that the doctor would have all my lab results. She also reviewed my medical history. I scheduled an appointment and was seen within a week. I arrived for my appointment and was escorted back to a examination room in a timely manner. I was seated in front of a monitor and two-way camera. The doctor introduced herself. She was very pleasant, did not appear rushed, and she was well prepared. It was evident based on her questions that she had reviewed my recent tests and medical history. During my appointment, the doctor ordered more tests and made a referral for a new medical condition she noted. She even apologized for not having the ability to examine me. Even more surprising, I received a call from her one week later with my test results.

In conclusion, I had a great experience with telemedicine. My appointment wait time was reduced from the normal two months to one week. My appointment started on time rather than the normal one hour lobby wait time. The doctor was not rushed during my appointment and took the time to listen to my concerns. The only obvious drawback is not having a doctor to physically examine you, but I would use telemedicine in the future. Telemedicine should be presented to veterans as an option for medical care, and not as a last resort.

Thank You

Zachary D. Walker

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### Prepared Statement of Herb Rogove

Thank you, Chairman Benishek and Ranking Member Brownley and Members of the Subcommittee. I am most appreciative for the opportunity and privilege to testify about telemedicine and in particular the critical role and contribution of the VA telehealth programs.

I am the physician founder and CEO of C3O Telemedicine which is based in Ojai, CA in Ventura County. My company was founded on the principle that no American

citizen should be penalized for gaining access to best practice medical care because of geography or no access to certain specialty physicians. To that end, we provide stroke care via telemedicine to over 30 hospitals located in soon to be seven states including CA. Additionally, I recently served on the Board of the American Telemedicine Association (ATA) as it's secretary/treasurer.

In January of 2015, Mr. Carl Blake, Associate Executive Director for Government Relations, Paralyzed Veterans of America testified before this same Committee and commented:

"the viability of the VA Healthcare System depends on upon a fully integrated system in which the organization and management of services are interdependent so that veterans get the care they need, when and where they need it, in a user-friendly way to achieve the desired results and provide value for the resources spent." The VA Telehealth program addresses his comment.

For the past ten years, I have studied many telehealth models and have been most impressed by the VA model as both exemplary and successful. In May, I had the privilege of meeting Dr. David Shulkin, Under Secretary of Health for the VA, at our national meeting. He shared that last year the VA had 2.4M encounters with 677,000 veterans (12% of all vets) using real-time telehealth, home telehealth care, and store and forward telemedicine. Forty-five percent of these encounters were in rural areas. The types of care provided varied from ICU, primary care, outpatient kiosks, sleep apnea and behavioral health. In 2015 home telehealth reduced hospital bed days of care by 58%; hospital admissions by 32%; and Telemental health reduced psych bed days of care by 35%.

Looking at the future, the VA Telehealth Model has a tremendous opportunity to:

- Serve as a national leader as VA telehealth programs continue to evolve.
- Partner with public-private partnerships with companies such as C3O Telemedicine as well as major health and academic systems to meet the current and expanding physician shortage.
- Establish a national medical license which is a significant barrier to telehealth. The VA has a national license, but outside of the VA, companies have to apply to many states costing time, money, and a significant delay up to one year to implement a program that a hospital needed yesterday.
- Push for CMS to expand reimbursement to Metropolitan Statistical Areas (MSA's).
- Evaluate and establish criteria for adequate and accurate technology that can serve our patients.

Thank you again for this opportunity.

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#### **Prepared Statement of Kevin Galpin, M.D.**

Good morning, Mr. Chairman, Ranking Member Brownley, and Members of the Committee. Thank you for the opportunity to discuss the efforts that VA has taken to develop telehealth, the services VA provides to Veterans through telehealth, and the expansion of telehealth at VA. I am accompanied today by Dr. Scotte R. Hartronft, Chief of Staff of the VA Greater Los Angeles Healthcare System (GLA).

Through the MyVA transformation, VA is working to rebuild trust with Veterans and the American people, improve service delivery, and set the course for long-term VA excellence, while delivering better access to care. MyVA will empower Veterans and their caregivers to be in control of their care and make interactions with VA a simple and exceptional experience. To empower Veterans, VA is transitioning to a system that is user-friendly and focused on contemporary practices in access to care. Accordingly, the Under Secretary for Health developed the "MyVA Access Declaration," a set of foundational principles for every VA employee. It represents VA's pledge to expand access to care for all Veterans seeking VA health services.

VA has substantially increased access to care for Veteran patients using telehealth services and is a recognized pioneer in the practice of telehealth. Since 2002, over two million Veterans have accessed VA care through telehealth services, and Veterans are utilizing more telehealth services from VA than ever before. In fiscal year (FY) 2015, VA conducted 2.14 million telehealth visits, reaching more than 677,000 Veterans. GLA, specifically, increased its outpatient encounters from the prior year by 61,500, including more than 20,000 telehealth visits that reached over 6,200 Veterans.

Leveraging telehealth technologies affords VA a noteworthy opportunity to increase access to care for Veterans, especially for those in rural or underserved areas. It allows Veterans access to VA health providers or services that may otherwise be

unobtainable locally. VA is recognized as a world leader in the development and use of telehealth, which is now considered mission critical for effectively delivering quality health care to Veterans. VA remains committed to ensuring that America's Veterans have access to the health care they have earned through their service, and we will continue to expand telehealth services to meet the growing needs of our Veterans.

### **Brief History of Telehealth**

The mission of VA Telehealth Services is to provide the right care in the right place at the right time through the effective, economical, and responsible use of health information and telecommunications technologies. Telehealth leverages health informatics, disease management principles, and communications technologies to deliver care and case management to Veterans. This aspect of telehealth changes the location where health care services can be provided, making care accessible to Veterans in their local communities and even in their homes.

VA leverages three broad categories of telehealth to deliver services to Veterans in 50 clinical specialties. The first of the three categories, Clinical Video Telehealth, is defined as the use of real-time interactive video conferencing to assess, treat, and provide care to a patient remotely. Typically, Clinical Video Telehealth links a Veteran at a clinic to a provider at a VA medical center in another location. Clinical Video Telehealth allows clinicians to engage patients in the comfort and convenience of their homes and facilitates delivery of a variety of clinical services including primary and specialty care. Clinical Video Telehealth means that instead of having the cost and inconvenience of the Veteran traveling by road, rail, or air to see a provider, the VA provider delivers care through telehealth to the Veteran.

VA Video Connect (VVC) represents the next step for Clinical Video Telehealth and is currently undergoing field testing. VVC provides fast, easy, encrypted, real-time access to VA care. VVC can be used to connect VA providers to a Veteran's personal mobile device, smartphone, tablet, or computer. It allows for video health care visits, such as telemental health visits, where a hands-on physical examination is not required. It also makes it easier for Veterans to choose where they'd like to receive services, whether that is in their home or any other place the Veteran desires.

The second broad category of telehealth is Home Telehealth. Home Telehealth uses VA-provided devices, along with regular telephone lines, mobile broadband modems, cell phones, or web browsers, to connect a Veteran with a VA provider, most often a registered nurse. Using Home Telehealth technologies, the VA provider can monitor the Veteran's health status, provide clinical advice, and facilitate patient self-management as an adjunct to traditional face-to-face health care. The goal of VA's Home Telehealth program is to improve clinical outcomes and access to care while reducing complications, hospitalizations, and clinic or emergency room visits for Veterans who are at high-risk due to a chronic disease (e.g. Diabetes). Not every patient is suitable for this type of care; however, for those Veterans who are, Home Telehealth can help them live independently and spend less time on medical visits. Over 85,000 Veterans are regularly using Home Telehealth services. VA found that patients easily learn how to use their Home Telehealth devices and are highly satisfied with the service. Home Telehealth services make it possible for Veterans to become more involved in their medical care and more knowledgeable about their conditions, providing an opportunity to more effectively self-manage their health care needs.

The third category of telehealth is Store-and-Forward Telehealth, which is the use of technologies to asynchronously acquire and store clinical information (such as data, images, sound, and video) that is then assessed by a provider at another location for clinical evaluation. VA's national Store- and-Forward Telehealth programs deliver such services as Dermatology and Retinal Screening, where a health care provider can use a photo or a series of photos for diagnosis or triage.

### **Examples of Telehealth Use**

#### ***Mental Health***

VHA uses information technology and telecommunication modalities to augment care provided by its mental health clinicians to Veterans throughout the United States. VA has found telemental health care to be equally effective, if not more so, than in-person appointments. From 2002 through July 2, 2016, more than 2 million telemental health visits have been provided to over 389,400 unique Veterans. Telemental health is also a way to bring highly specialized care to patients who otherwise would have to travel great distances to receive such care.



VA's National Telemental Health Center (NTMHC) provides Veterans throughout the country with access to the highest level of clinical experts using telemedicine. The NTMHC clinical national experts (in affective, psychotic, anxiety, and substance use disorders) are located at the VA Boston Healthcare System, the VA Connecticut Healthcare System, the Philadelphia VA Medical Center (VAMC), and the Providence VAMC. The NTMHC has provided access and expert consultation to over 4,600 Veterans for more than 16,500 encounters at over 120 sites throughout the Nation. Building on the success of NTMHC, in 2016, VA announced the establishment of four regional Telemental Health Hubs, with mental health providers at these hubs available for facilities in need of mental health resources.

### ***Rehabilitation***

Rehabilitation providers leverage video conferencing to increase access to specialty rehabilitation care. In FY 2015, over 57,000 rehabilitation encounters occurred using this modality, providing care to over 33,000 unique Veterans. Numerous specialty rehabilitation clinics are offered through telehealth, including, but not limited to, Amputation, Blind Rehabilitation, Physical Therapy, Speech Therapy, and Traumatic Brain Injury. Clinical Video Telehealth allows the rehabilitation provider to be located at a tertiary medical center while the patient is at a Community Based Outpatient Clinic (CBOC), another VAMC, or a non-VA location. Veterans with disabilities, especially in rural areas, benefit greatly from telerehabilitation. Many of these Veterans have mobility issues and/or socioeconomic factors that affect their ability to travel to receive needed care. Telerehabilitation increases access to specialty rehabilitation therapies, which assists in increasing functional gains and social re-integration.

Tele-Intensive Care (Tele-ICU) is a telemedicine program that links Intensive Care Units (ICU) in VA medical centers to a central monitoring hub staffed with intensivist physicians and experienced critical care nurses. Through the use of a camera mounted above each patient's ICU bed, along with links to the medical record and vital sign monitors, staff in the Tele-ICU hub not only see all of the pertinent medical data on a patient, but they are capable of performing audiovisual exams; discussing treatment plans with patients, nurses, and families; intervening during emergencies; and generally providing specialist-level care and consultation.

### ***Store-and-Forward Retinal Imaging***

Diabetes can cause problems with the blood vessels in the retina, especially if the diabetes is poorly controlled. A special camera takes pictures of the retina, which are then sent to an eye care specialist for review. A report is returned to the patient's primary care physician, who can provide any required treatment. This investigation does not replace a full eye exam but does mean that those at risk of eye problems from diabetes can be assessed easily and conveniently in a local clinic.

### ***Telesurgery***

Telesurgical consultation can enhance the diagnosis, the coordination of care, and the triage of surgical patients. The use of telehealth can provide intra-operative consultation, patient and staff education, and pre- and post-operative assessment.

We continually add new telehealth specialties as technology improves, allowing VA to integrate telehealth technologies into more areas of Veteran care. These technologies make it possible for Veterans to come to many of VA's CBOCs and connect to a specialist physician or another practitioner at a distant location.

### ***Telehealth Potential***

Though advanced compared to other health care systems, VA is still at the beginning of its journey of leveraging its integrated national health care system and remote care opportunities through telehealth technologies. VA would be able to accelerate expansion of clinical services if our clinical and technical capabilities to deliver health care through virtual technologies were supported by legal authority, unambiguously authorizing health care providers to deliver clinical services irrespective of the Veteran's or the provider's location.

### ***Conclusion***

In closing, VA is a leader in providing telehealth services, which remains a critical strategy in ensuring Veterans can access health care when and where they need it. With the support of Congress, we have an opportunity to shape the future and ensure that VA is leveraging cutting-edge technology to provide convenient, accessible, high-quality care to all Veterans.

Mr. Chairman, this concludes my testimony. Thank you for the opportunity to testify before the Committee today. We appreciate your support and look forward to responding to any questions you and Members of the Committee may have.

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**Statement For The Record**

**GRACE HEALTH SYSTEM - DR. RANDALL SCOTT HICKLE, M.D.**

**Dr. Randall Scott Hickle, MD, Founder/CEO, Grace Health System, Lubbock, Texas**

MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE, thank you for hosting this important oversight hearing today on the topic of telemedicine in the VA Healthcare System. This is a vitally important technology that can increase much needed access to care for our veterans at a significantly reduced cost. It is my pleasure to participate in this hearing and share some private sector solutions for the VA Healthcare crisis.

**STATEMENT**

My name is Dr. Randy Hickle, MD and I am the Founder/CEO of the Grace Health System located in Lubbock, Texas. Grace Health System started in 2006 as Grace Clinic with just eight doctors on staff. Over the past decade, we have grown to more than 50 doctors and other specialists along with 22 centers of care offering patient-centered care to people from all of over the West Texas region.

The growth of Grace doesn't end there. Since 2012, we have started a new hospital, upgraded the in-house pharmacy, opened a new cardiac imaging center, and added 15 new doctor's offices. We are also changing the region's medical landscape by breaking ground on a new 350,000 square-foot hospital in the next several months. More importantly, we are planning for the future of medicine and have launched a telemedicine program reaching medically underserved and chronically ill patients in rural communities throughout Texas and New Mexico. It is Grace's telemedicine program that has inspired me to share my thoughts with you today.

While West Texas comprises almost half the state in geographic size, it is home to mostly rural towns that make up only 12 percent of the state of Texas' population. Telemedicine provides a way for these rural patients to receive critical access to care by eliminating the cost and inconvenience of traveling to a population center. We are experiencing great success in monitoring and treating patients that otherwise may have gone untreated which often result in higher costs to the overall system from unnecessary hospitalizations and ER admissions. About a year-and-a-half ago after reading about some of the tragic consequences of some of our veterans that are committing suicide at alarming rates, I decided that it was time to employ some of the telemedicine successes we are experiencing in the private sector with the VA.

Last year, I was honored to visit with House Veteran's Affairs Committee Chairman Jeff Miller (R-Florida) and his staff about my successful experiences with treating patients through Grace's telemedicine program and how I would like to help provide such a solution to our veterans who have given so much for their country. We owe them nothing less. Chairman Miller and his staff have been supportive of my efforts to provide proven private sector solutions to address this VA Healthcare crisis. Unfortunately, my attempts to collaborate with the VA directly have been frustrating.

I was encouraged to hear VA Secretary Robert A. McDonald state recently, "A brick-and-mortar facility is not the only option for health care. We are exploring how we can more efficiently and effectively deliver health care services to better serve our veterans and improve their lives. Telehealth is one of those areas we have identified for growth."

I could not agree more with Secretary McDonald. And I would implore the Secretary and the Members of this Subcommittee to not reinvent the wheel with telemedicine. There are many talented and successful telemedicine programs that are currently available to immediately assist with the VA's alarming backlog. In September 2015, the Texas VA facilities required a wait time of over 30 days for 34,665 appointments. This is unacceptable, and we can do much better.

My whole career has been focused on creating innovative solutions for areas where I see real health care needs. Your decision to hold this hearing today tells me that you all feel the same way. There are many private sector solutions across this great country, and I would strongly encourage you to review the Grace Veterans Telehealth Initiative. I believe telemedicine can improve health care for all veterans

by improving accessibility, affordability, and accountability. I collaborated with a leading expert in addiction recovery, Dr. Kitty Harris, to create a behavioral health program for veterans that would serve their needs for PTSD, depression, anxiety, and substance abuse. I have asked that a one-page summary be submitted to the record for your review and consideration.

Once again, I thank Chairman Dan Benishek, MD and the distinguished Members of the Subcommittee on Health for hosting today's Oversight hearing on Telemedicine in the VA System. This is a very important and vital health care solution that deserves a congressional hearing. I would also like to thank House Veterans' Affairs Committee Chairman Jeff Miller (R-Florida) and Ms. Christine Hill, Staff Director, Subcommittee on Health for their continued leadership to find proven telemedicine techniques that increase access to quality care for our veteran patients.

### **Veterans Telehealth Initiative**

#### *Expanding Behavioral Health Access*

#### **Overview**

Many veterans who need behavioral health services do not receive it. Those who do seek out services frequently terminate prematurely (1). It is hypothesized that veterans engage in treatment less often for the following reasons (2, 3): transportation costs, fear of stigmatization for receiving behavioral health services, living in rural areas, provider shortage areas that lack mental health specialists. Telemedicine has proven to be effective for treatment of behavioral health conditions and addresses the reasons for lack of services among veterans. Telemedicine has been proven effective for a variety of conditions including:

- Post-Traumatic Stress Disorder (4)
- Anxiety Disorders (5)
- Depression (6)
- Acute Suicidality (6)
- Eating Disorders (7)
- Smoking Cessation (8)

It is well known that frequency of therapy is highly tied to efficacy (9). However, issues such as worktimes and available childcare still impede veterans from receiving services. Psychoeducation is also known to enhance the efficacy of treatment (10). Maintaining high engagement is critical for disseminating psychoeducation. The Veterans Telehealth Initiative (VTI) Program provides solutions to both of these issues by removing common barriers (e.g., location, childcare), allowing high frequency therapy, and highly engaging video-based psychoeducation.

#### **Evidence-Based Programs**

**Post-Traumatic Stress Disorder:** Trauma-Focused Cognitive Behavioral Therapy

**Substance Use Disorders:** 12-Step Facilitation Education, CBT, and Mindfulness

**Depression:** Behavioral Activation and Cognitive Behavioral Therapy

**Obsessive Compulsive Disorder:** Exposure and Response Prevention and CBT

**Panic Disorder:** Relaxation, Panic Induction and Reaction, and CBT

#### **Professional Services Provided:**

- Psychotherapy weekly
- Telepsychiatry PRN
- Telemonitoring of symptoms
- Multidisciplinary treatment team meetings
- Personalized feedback, which has been shown to enhance electronically mediated treatment (11)

#### **Example Program Overview: Alcohol Use Disorder Treatment**

A typical program covers approximately one month of intensive treatment. All 4 science-based treatments are included. The program includes interactive feedback, peer-facilitated components, multimedia rich presentation, and a holistic approach with links to other mental health treatment programs.

Week 1	Motivational Enhancement	Contingency Management
Week 2	Cognitive Behavioral Therapy	Contingency Management
Week 3	Cognitive Behavioral Therapy Mindfulness Treatment	Contingency Management
Week 4	Mindfulness Treatment	Contingency Management

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